IDAHO MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

Updated:
May 6, 2007

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
ACE INHIBITORS ***Effective 10/1/06***	**ACE INHIBITORS**		Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months.
	ACEON (perindopril) ALTACE (ramipril) benazepril captopril enalapril lisinopril	fosinopril MAVIK (trandolapril) moexepril quinapril	
	ACE INHIBITOR/DIURETIC COMBINATIONS		Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months.
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ	fosinopril/HCTZ moexepril/HCTZ quinapril/HCTZ	
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS	LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil)	LEXXEL (enalapril/felodipine)	Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
ALZHEIMER'S AGENTS[CL] *Effective 10/1/06*	**CHOLINESTERASE INHIBITORS**		Cholinesterase inhibitors will be approved only for patients meeting both of the following criteria: • Diagnosis of dementia (ICD-9=290.xx, 294.1, 331.0) • Mini Mental State Exam (MMSE) score of ≤23 or equivalent scale documenting mild to moderate dementia Non-Preferred agents will be approved for patients meeting at least one of the following criteria: • Documented history of failure to Preferred agents within previous 6 months • More than 120 days of therapy with the same Non-preferred agent in the previous 6 months
	ARICEPT (donepezil) ARICEPT ODT (donepezil) EXELON (rivastigmine)	COGNEX (tacrine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	NMDA RECEPTOR ANTAGONIST		Namenda will be approved only for patients meeting both of the following criteria: • Diagnosis of dementia (ICD-9=290.xx, 294.1, 331.0) • Mini Mental State Exam (MMSE) score of ≤15 or equivalent scale documenting moderate to severe dementia
	NAMENDA (memantine)		

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ANALGESICS, NARCOTIC - SHORT-ACTING (Non-parenteral) *Effective 4/1/07* *Implement 4/1/07*	acetaminophen/codeine aspirin/codeine codeine hydrocodone/APAP hydromorphone levorphanol morphine oxycodone oxycodone/APAP oxycodone/aspirin pentazocine/naloxone propoxyphene/APAP tramadol	butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine COMBUNOX (oxycodone/ibuprofen) DARVON N (propoxyphene) dihydrocodeine/ APAP/caffeine fentanyl transmucosal FENTORA (fentanyl)[NR] hydrocodone/ibuprofen meperidine OPANA (oxymorphone) PANLOR (dihydrocodeine/APAP/caffeine) pentazocine/APAP propoxyphene propoxyphene/ASA/caffeine tramadol/APAP	Non-preferred agents will be approved only after documented failure of 3 preferred agents. Fentanyl transmucosal will only be approved for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.
ANALGESICS, NARCOTIC - LONG-ACTING (Non-parenteral) *Effective 4/1/07* *Implement 4/1/07*	morphine SR methadone levorphanol KADIAN (morphine) DURAGESIC (fentanyl)[CL]	AVINZA (morphine) oxycodone ER fentanyl patches OPANA ER (oxymorphone) OXYCONTIN (oxycodone)	Duragesic patches will be approved for patients meeting one of the following criteria: • Inability to swallow capsules or tablets • Allergy to morphine and/or methadone • History of a preferred oral agent in previous 6 months Non-preferred agents will be approved for patients meeting one of the following criteria: • Documented failure of at least a 30 day trial of a Preferred agent within previous 6 months • Diagnosis of malignant pain (ICD-9=140-208, 99.25 or chemotherapy administration related CPT code)
ANDROGENIC AGENTS (Topical) ***Effective 10/1/06***	**ANDRODERM (testosterone)** **ANDROGEL (testosterone)**	**TESTIM (testosterone)**	The non-preferred agent will be approved only after documented failure of the preferred agents within the last 6 months.

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ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)	**ANGIOTENSIN II RECEPTOR BLOCKERS**		Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) TEVETEN (eprosartan**)**	
	ARB/DIURETIC COMBINATIONS		Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ)	
ANTICOAGULANTS, INJECTABLE *Effective 4/1/07* *Implement 4/1/07*	ARIXTRA (fondaparinux) FRAGMIN (dalteparin) LOVENOX (enoxaparin)	INNOHEP (tinzaparin)	Non-preferred agents will be approved only after documented failure of a preferred agent.
ANTCONVULSANTS *Effective 4/1/07* *Implement 5/1/07*	**BARBITURATES**		
	MEBARAL (mephobarbital) phenobarbital primidone		
	BENZODIAZEPINES		
	clonazepam DIASTAT (diazepam rectal)		
	HYDANTOINS		The non-preferred agent will be approved only after documented failure of a preferred agent.
	DILANTIN (phenytoin) PEGANONE (ethotoin) phenytoin	PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide		

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	ADJUVANTS		Keppra and zonisamide will be approved for patients with a diagnosis of seizure disorder (ICD-9=345) wihin the previous 2 years. Lamictal and Trileptal will be approved for patients with one of the following diagnoses within the previous 2 years: • Seizure disorder (ICD-9=345) • Bipolar disorder (ICD-9=296) Lyrica will be approved for patients meeting one of the following criteria: • Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (ICD-9=250.6) or postherpetic neuralgia (ICD-9=053.1) which has failed treatment with gabapentin in the last 2 years. • Diagnosis of epilepsy (ICD-9=345) which has failed treatment with one other antiepileptic agents in the last 2 years. Topamax will be approved for patients with one of the following diagnoses within the previous 2 years: • Seizure disorder (ICD-9=345) • Migraine headache (ICD-9=296) Patients currently receiving Tegretol XR will be grandfathered and not need switch to a preferred agent.
	carbamazepine CARBATROL (carbamazepine) DEPAKOTE (divalproex) EQUETRO (carbamazepine) gabapentin GABITRIL (tiagabine) KEPPRA (levetiracetam)[CL] LAMICTAL (lamotrigine)[CL] LYRICA (pregabilin)[CL] TOPAMAX (topiramate)[CL] TRILEPTAL (oxcarbazepine)[CL] valproic acid zonisamide[CL]	FELBATOL (felbamate) lamotrigine TEGRETOL XR (carbamazepine)	
ANTIDEPRESSANTS, SSRIs	citalopram fluoxetine fluvoxamine LEXAPRO (escitalopram) PAXIL CR (paroxetine) ZOLOFT (sertraline)	PROZAC WEEKLY (fluoxetine) paroxetine PEXEVA (paroxetine) sertraline	Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
ANTIDEPRESSANTS, OTHER *Effective 4/1/07* *Implement 5/1/07*	bupropion bupropion SR EFFEXOR XR (venlafaxine) mirtazapine tablets WELLBUTRIN XL (bupropion)	bupropion XL CYMBALTA (duloxetine) EMSAM (selegiline transdermal) mirtazapine soluble tablets nefazodone venlafaxine	Cymbalta will be approved for patients meeting one of the following criteria: - Diagonsis of major depressive disorder (MDD) or generalized anxiety disorder (GAD) who have tried and failed treatment with a preferred antidepressant - Diagnosis of diabetic peripheral neuropathy (DPN) who have tried and failed gabapentin therapy in the past 6 months Emsam will be approved for patients meeting all of the following criteria: - age ≥18 years - diagonosis of major depressive disorder (MDD) - failure of trials of an SSRI, an SNRI and at one least one other antidepressant from another therapeutic class - not currently receiving any contraindicated medications - no diagnosis of pheochromocytoma Patients currently on Cymbalta or venlafaxine will be authorized to continue on that agent.
ANTIEMETICS[CL] **(Oral)**	**5HT3 RECEPTOR BLOCKERS**		$5HT_3$ Receptor Blockers will be approved only for patients meeting one of the following criteria: • Chemotherapy-induced nausea and vomiting • Radiation-induced nausea and vomiting • Hyperemesis gravidarum (ICD-9=643.1) that has failed at least 72 hours of at least one of the following therapies: - promethazine 150 mg/day - prochlorperazine 20 mg/day - trimethobenzamide 1200 mg/day - metoclopramide 80 mg/day Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron)	ANZEMET (dolasetron) KYTRIL (granisetron) ondansetron	
	NMDA RECEPTOR ANTAGONIST		Emend will be approved only for patients who have had a prescription for Anzemet, Kytril or Zofran within the past 30 days.
	EMEND (aprepitant)[CL]		

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ANTIFUNGALS, ORAL	ANCOBON (flucytosine) clotrimazole fluconazole ketoconazole nystatin VFEND (voriconazole)	GRIFULVIN V (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole LAMISIL (terbinafine) NOXAFIL (posaconazole)[NR]	Itraconazole and Lamisil will be approved for patients with a diagnosis of aspergillosis (ICD-9=117.3), blastomycosis (ICD-9=116.xx) or histoplasmosis (ICD-9=115.xx). Lamisil will be approved for patients with a diagnosis of onychomycosis (ICD-9=110.1) with confirmation by microbiological or histological test and extensive nail involvement resulting in significant debilitation or secondary infection. Griseofulvin products will be approved for patients meeting one of the following criteria: • Diagnosis of tinea capitis • Tinea corporis, cruris or pedis failing to respond to at least 2 weeks of a topical agent
ANTIFUNGALS, TOPICAL	**ANTIFUNGALS**		Penlac will only be approved only for patients meeting all fo the following criteria: • Diagnosis of onychomycosis (ICD-9=110.1) within the last year • Contraindication to oral itraconazole and Lamisil as defined by presence of heart failure, hepatic impairment or viral hepatitis • Proof from prescriber that therapy is not for cosmetic purposes. Other non-preferred agents will be approved only after documented failure of the preferred agents within the previous six months.
	econazole EXELDERM (sulconazole) ketoconazole NAFTIN (naftifine) nystatin	ciclopirox PENLAC (ciclopirox) ERTACZO (sertaconazole) LOPROX (ciclopirox) MENTAX (butenafine) OXISTAT (oxiconazole) VUSION (miconazole/petrolatum/zinc oxide)[NR] XOLEGEL (miconazole)[NR]	
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone		

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ANTIHISTAMINES, MINIMALLY SEDATING[CL] *Effective 4/1/07* *Implement 5/1/07*	**ANTIHISTAMINES**		A prescription is required for all agents. Preferred agents will be approved for patients with a diagnosis of allergic rhinits or chronic urticaria. Non-preferred agents will be authorized if a patient has failed a preferred agent within the most recent six months. Clarinex syrup is a preferred agent for patients ≤12 years of age,
	CLARINEX Syrup (desloratadine) loratadine	ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) fexofenadine ZYRTEC (cetirizine)	
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	loratadine/pseudoephedrine SEMPREX-D (acrivastine/pseudoephedrine)	ALLEGRA-D (fexofenadine/pseudoephedrine) CLARINEX-D (desloratadine/pseudoephedrine) ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS[CL] *Effective 4/1/07* *Implement 5/1/07*	**ORAL**		Triptans will be approved for patients meeting all of the following criteria: - Age ≥12 years - No history of CAD, angina, uncontrolled HPT, CVD, PVD, ischemic bowel disease Non-preferred agents will be approved only if patient has tried and failed therapy with all of the preferred agents within the last 6 months. Patients currently receiving a non-preferred agent will be authorized to continue on that drug.
	AMERGE (naratriptan) IMITREX (sumatriptan) MAXALT (rizatriptan)	AXERT (almotriptan) FROVA (frovatriptan) RELPAX (eletriptan) ZOMIG (zolmitriptan)	
	NASAL		
	IMITREX (sumatriptan)	ZOMIG (zolmitriptan)	
	INJECTABLE		
	IMITREX (sumitriptan)		
ANTIPARKINSON'S AGENTS (Oral)	**ANTICHOLINERGICS**		
	benztropine KEMADRIN (procyclidine) trihexyphenidyl		
	COMT INHIBITORS		The non-preferred agent will be approved only after documented failure of the preferred agent.
	COMTAN (entacapone)	TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	MIRAPEX (pramipexole) REQUIP (ropinirole)		
	MAO-B INHIBITORS		
	selegiline	AZILECT (rasagiline)[NR] ZELAPAR (selegiline)[NR]	

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	OTHER ANTIPARKINSON'S AGENTS		The non-preferred agent will be approved only after documented failure of the preferred agent.
	carbidopa/ levodopa STALEVO (levodopa/carbidopa/entacapone)	PARCOPA (levodopa/carbidopa)	
ANTIVIRALS (Oral)	**ANTI-CMV AGENTS**		
	ganciclovir VALCYTE (valganciclovir)		
	ANTIHERPETIC AGENTS		
	acyclovir FAMVIR (famciclovir) VALTREX (valacyclovir)		
	ANTIINFLUENZA AGENTS		
	amantadine RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir)		
ATOPIC DERMATITIS	ELIDEL (pimecrolimus PROTOPIC (tacrolimus)		
BETA BLOCKERS (Oral)	**BETA BLOCKERS**		Innopran XL and Levatol will be approved for patients with documented failure to one of the preferred agents within the past 6 months.
	acebutolol atenolol betaxolol bisoprolol metoprolol nadolol pindolol propranolol sotalol timolol TOPROL XL (metoprolol)	INNOPRAN XL (propranolol) LEVATOL (penbutolol)	
	BETA- AND ALPHA- BLOCKERS		Coreg will be approved only for patients with a documented diagnosis of heart failure. The non-preferred agent will be approved only after documented failure of a preferred agent.
	COREG (carvedilol)[CL] labetalol	COREG CR (carvedilol)[NR]	

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BLADDER RELAXANT PREPARATIONS	DITROPAN XL (oxybutynin) ENABLEX (darifenacin) oxybutynin OXYTROL (oxybutynin) SANCTURA (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine)	Non-preferred agents will be approved for patients with documented failure (inability to maintain continence) of, or intolerance (dry mouth) to, on a preferred agent.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS	BISPHOSPHONATES		Non-preferred agents will be approved only after documented failure of the preferred agents.
	BONIVA (ibandronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) DIDRONEL (etidronate)	
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	EVISTA (raloxifene) MIACALCIN (calcitonin)	FORTEO (teriparatide) FORTICAL (calcitonin)	
BPH AGENTS *Effective 4/1/07* *Implement 5/1/07*	**ALPHA BLOCKERS**		
	CARDURA XL (doxazosin) doxazosin FLOMAX (tamsulosin) terazosin UROXATRAL (alfuzosin)		
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	AVODART (dutasteride) finasteride		
BRONCHODILATORS, ANTICHOLINERGIC	ANTICHOLINERGIC		
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)		
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		DuoNeb will be approved only after documented failure of the separate components.
	COMBIVENT (albuterol/ipratropium)	DUONEB (albuterol/ipratropium)	

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BRONCHODILATORS, BETA AGONIST	**INHALERS, SHORT-ACTING**		The non-preferred agent will be approved only after documented failure of the preferred agents.
	albuterol MAXAIR (pirbuterol) PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	ALUPENT (metaproterenol)	
	INHALERS, LONG-ACTING		Long-acting beta agonist inhalers will be approved for patients with moderate or severe persistent asthma who are currently receiving inhaled corticosteroids.
		FORADIL (formoterol) SEREVENT (salmeterol)	
	INHALATION SOLUTION		Non-preferred agents will be approved for patients with documented failure of the preferred agents.
	albuterol	ACCUNEB (albuterol) metaproterenol XOPENEX (levalbuterol)	
	ORAL		Non-preferred agents will be approved only after documented failure of the preferred agents.
	albuterol terbutaline	metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS (Oral) *Effective 4/1/07* *Implement 5/1/07*	**SHORT-ACTING**		Nifedipine will be approved only for patients with documented chronic stable angina or vasospastic angina. Isradipine and nicardipine will be approved only for patients failing therapy with the corresponding long-acting dosage form.
	diltiazem NIMOTOP (nimodipine) verapamil	isradipine nicardipine nifedipine	
	LONG-ACTING		Non-preferred agents will be approved only after documented failure of the preferred agents.
	CARDIZEM LA (diltiazem) diltiazem ER DYNACIRC CR (isradipine) felodipine ER nifedipine ER NORVASC (amlodipine) SULAR (nisoldipine) TIAZAC 420 mg (diltiazem) verapamil ER VERELAN PM (verapamil)	amlodipine CARDENE SR (nicardipine) COVERA-HS (verapamil)	

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CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	**BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS**		
	amoxicillin/clavulanate AUGMENTIN XR (amoxicillin/clavulanate)		
	CEPHALOSPORINS – First Generation		The non-preferred agent will be approved only after documented failure of the preferred agents.
	cefadroxil cephalexin cephradine	PANIXINE (cephalexin)	
	CEPHALOSPORINS – Second Generation		The non-preferred agents will be approved only after documented failure of the preferred agents.
	cefaclor cefprozil cefuroxime	LORABID (loracarbef) RANICLOR (cefaclor)	
	CEPHALOSPORINS – Third Generation		
	CEDAX (ceftibuten) cefpodoxime OMNICEF (cefdinir) SPECTRACEF (cefditoren) SUPRAX (cefixime)		
CYTOKINE & CAM ANTAGONISTS	AMEVIVE (alefacept) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) RAPTIVA (efalizumab) REMICADE (infliximab)		
ERYTHROPOIESIS STIMULATING PROTEINS	ARANESP (darbepoetin) PROCRIT (rHuEPO)	EPOGEN (rHuEPO)	Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agent within the last 6 months.

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ESTROGENS	ORAL		
	CENESTIN (conjugated estrogens, synthetic) estradiol estropipate FEMTRACE (estradiol) GYNODIOL 1.5 mg (estradiol) MENEST (estrogens, esterified) PREMARIN (estrogens, conjugated)		
	TRANSDERMAL		
	ALORA (estradiol) CLIMARA (estradiol) ESCLIM (estradiol) ESTRADERM (estradiol) estradiol ESTROGEL (estradiol) MENOSTAR (estradiol) VIVELLE (estradiol) VIVELLE-DOT (estradiol)		
	VAGINAL		
	ESTRING (estradiol) FEMRING (estradiol) OGEN (estropipate) PREMARIN (estrogens, conjugated) VAGIFEM (estadiol)	ESTRACE (estradiol)	The non-preferred agent will be approved only after documented failure of the preferred agents.
FLUOROQUINOLONES, ORAL	AVELOX (moxifloxacin) CIPRO Suspension (ciprofloxacin) ciprofloxacin	CIPRO XR (ciprofloxacin) FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) ofloxacin PROQUIN XR (ciprofloxacin)	Non-preferred agents will be approved only after documented failure of the preferred agents.

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GLUCOCORTICOIDS, INHALED	GLUCOCORTICOIDS		Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agents within the last 6 months. Pulmicort Respules will not require a prior authorization for children 1-8 years of age,
	AEROBID (flunisolide) AEROBID-M (flunisolide) AZMACORT (triamcinolone) ASMANEX (mometasone) QVAR (beclomethasone)	FLOVENT HFA (fluticasone) PULMICORT (budesonide)	
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		Advair will be approved only for patients with documented moderate or severe persistent asthma or COPD. Patients currently on Advair will be approved to continue on that agent.
		ADVAIR (fluticasone/salmeterol)	
GROWTH HORMONE[CL] *Effective 4/1/07* *Implement 5/1/07*	GENOTROPIN (somatropin) NUTROPIN AQ (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin)	HUMATROPE (somatropin) NUTROPIN (somatropin) NORDITROPIN (somatropin) OMNITROPE (somatropin)[NR] ZORBTIVE (somatropin)	Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: • Chronic Renal Impairment awaiting renal transplantation (ICD-9 585) • Growth Hormone Deficiency (ICD-9=253.2, 253.3) • Prader-Willi Syndrome (ICD-9=759.81) • Turner Syndrome (ICD-9=758.6) • HIV plus Cachexia (ICD-9=042, 079.53, V08 or 795.71 plus 799.4) Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agents within the last 6 months. Patients currently on a non-preferred agent will be approved to continue therapy with that agent.
HEPATITIS C TREATMENTS *Effective 4/1/07* *Implement 5/1/07*	INTERFERON		The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months. Patients currently on PEG-Intron will be approved to continue therapy with that agent.
	PEGASYS (pegylated interferon alfa-2a)	INFERGEN (consensus interferon) PEG-INTRON (pegylated interferon alfa-2b)	
	RIBAVIRIN		Non-preferred agents will be approved only after documented failure of the preferred agent.
	ribavirin	COPEGUS (ribavirin) REBETOL (ribavirin)	

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IDAHO MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

Updated:
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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS	INSULIN, INJECTABLE		
	HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine)	Apidra will be approved for patients with documented hypoglycemia with Humalog or Novolog.
	INSULIN, INHALATION		Exubera will be approved for patients meeting all of the following criteria: - Age ≥18 years - Diagnosis of diabetes mellitus - Physically unable to inject insulin (e.g., blindness or other physical impairment) - No documented history of smoking or chronic lung disease in the past 2 years - If diagnosis is type 2 diabetes, patient must have failed or not be a candidate for combination oral therapy at maximum doses and there must be documentation of an HbA1c not within accepted range
		EXUBERA (insulin, inhaled)[NR]	
	AMYLIN ANALOGS		Symlin will be approved for adult diabetics meeting all of the following criteria: - $HbA1_C$ in past six months - No history of gastroparesis, neurologic manifestations of diabetes or recent treatment of hypoglycemia.
	SYMLIN (pramlintide)[CL]		
	INCRETIN MIMETICS		Byetta will be approved for patients with type 2 diabetes mellitus who are taking a sulfonylurea, metformin, thiazolidinedione (TZD) or a combination of metformin and a sulfonylurea or TZD, but who have not achieved adequate glycemic control.
	BYETTA (exenatide)[CL]		
HYPOGLYCEMICS, MEGLITINIDES	PRANDIN (repaglinide) STARLIX (nateglinide)		

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HYPOGLYCEMICS, SULFONYLUREAS	acetohexamide chlorpropamide glimepiride glipizide glyburide	tolazamide tolbutamide	
HYPOGLYCEMICS, TZDS ***Effective 4/1/07*** ***Implement 4/1/07***	**THIAZOLINEDIONES**		
	ACTOS (pioglitazone) AVANDIA (rosiglitazone)		
	TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride)		
INTRANASAL RHINITIS AGENTS	ANTICHOLINERGICS		
	ipratropium		
	ANTIHISTAMINES		
	ASTELIN (azelastine)		
	CORTICOSTEROIDS		Non-preferred agents will be approved only after documented failure of the preferred agents.
	FLONASE (fluticasone) NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide fluticasone NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
LEUKOTRIENE MODIFIERS		ACCOLATE (zafirlukast) SINGULAIR (montelukast) ZYFLO (zafirlukast)	Leukotriene modifiers will be approved for patients with one of the following diagnoses: • asthma (ICD-9=493.00, 493.01, 493.02) AND - are ≤16 years of age - are >16 years of age and are currently on or have failed therapy with an inhaled corticosteroid ▪ allergic rhinitis (ICD-9=477.xx)

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IDAHO MEDICAID

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
LIPOTROPICS, OTHER (non-statins) ***Effective 4/1/07*** ***Implement 4/1/07***	**BILE ACID SEQUESTRANTS**		The non-preferred agent will be approved only after documented failure of the preferred agents.
	cholestyramine colestipol	WELCHOL (colesevalam)	
	CHOLESTEROL ABSORPTION INHIBITORS		Zetia will be approved for patients who have a diagnosis of hypercholesterolemia and have either failed statin monotherapy or have a documented intolerance to statins. Zetia treatment is only approved as an adjunct to concurrent statin therapy unless there is a documented intolerance to the statins
		ZETIA (ezetimibe)	
	FIBRIC ACID DERIVATIVES		Non-preferred agents will be approved only after documented failure of the preferred agents.
	fenofibrate gemfibrozil TRICOR (fenofibrate)	ANTARA (fenofibrate) TRIGLIDE (fenofibrate)	
	NIACIN		Non-preferred agents will be approved only after documented failure of the preferred agents.
	NIASPAN (niacin)	NIACELS (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
	OMEGA-3 FATTY ACIDS		
		OMACOR (omega-3 fatty acids)	
LIPOTROPICS, STATINS	**STATINS**		Statins will be approved only for patients ≥8 years of age Crestor will be approved for patients with documented failure of 2 preferred agents or 2 different doses of a single preferred agent for at least 150 days in the last 6 months. A quantity limit of one dosage per day applies to all but the highest strength of each agent.
	ALTOPREV (lovastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) lovastatin pravastatin simvastatin	CRESTOR (rosuvastatin)	
	STATIN COMBINATIONS		Caduet will be approved for patients with documented failure of 2 preferred agents or 2 different doses of a single preferred agent for at least 150 days in the last 6 months. Vytorin will be approved for patients failing a minimum 3 month trial of standard dose statin.
	ADVICOR (lovastatin/niacin)	CADUET (atorvastatin/amlodipine) VYTORIN (simvastatin/ezetimibe)	

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MACROLIDES / KETOLIDES	**KETOLIDES**		Ketek will be approved if there is documentation of any antibiotic use within the past 28 days.
		KETEK (telithromycin)	
	MACROLIDES		
	azithromycin BIAXIN XL (clarithromycin) clarithromycin erythromycin ZMAX (azithromycin)		
MULTIPLE SCLEROSIS AGENTS	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)		

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
NSAIDS	**NONSELECTIVE**		Non-preferred agents will be approved only after documented failure of the preferred agents.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketorolac naproxen oxaprozin piroxicam PONSTEL (mefenamic acid) sulindac	ketoprofen meclofenamate nabumetone tolmetin	
	NSAID/GI PROTECTANT COMBINATIONS		Non-preferred agents will be approved for patients with rheumatoid arthritis, osteoarthritis, acute pain or dysmenorrhea and who have any of the following risk factors for a GI bleed: • previous or current PUD or GI bleed • concurrent therapy with corticosteroids, anticoagulants or antiplatelets • inability to tolerate at least two nonselective NSAIDs Celecoxib will be approved for patients with Familial Adenomatous Polyposis Acute pain treatment is limited to 14 days
		ARTHROTEC (diclofenac/misoprostol) PREVACID NAPRAPAC (naproxen/lansoprazole)	
	COX-II SELECTIVE		
		CELEBREX (celecoxib) meloxicam	
OPHTHALMIC ANTIBIOTICS	FLUOROQUINOLONES		Non-preferred agents will be approved only after documented failure of the preferred agents.
	VIGAMOX (moxifloxacin)	CILOXAN (ciprofloxacin) ciprofloxacin ofloxacin QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	

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	NON-FLUOROQUINOLONES		
	bacitracin erythromycin gentamicin polymyxin B sulfacetamide tobramycin		
	COMBINATION AGENTS		
	neomycin/polymyxin/bacitracin neomycin/polymyxin/gramicidin polymyxin/bacitracin polymyxin/trimethoprim		
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	ACULAR (ketorolac) ALREX (loteprednol) cromolyn ELESTAT (epinastine) PATADAY (olopatadine)[NR] PATANOL (olopatadine)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) EMADINE (emedastine) ketotifen OPTIVAR (azelastine)	Non-preferred agents will be approved only after documented failure of the preferred agents.
OPHTHALMICS, GLAUCOMA AGENTS	PARASYMPATHOMIMETICS		
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine		
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine dipivefrin		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
	BETA BLOCKERS		
	BETIMOL (timolol) BETOPTIC S (betaxolol) betaxolol carteolol ISTALOL (timolol) levobunolol metipranolol timolol		
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost) XALATAN (latanoprost)		
	COMBINATION AGENTS		
	COSOPT (dorzolamide/timolol)		
OTIC FLUOROQUINOLONES ***Effective 4/1/07*** ***Implement 4/1/07***	CIPRODEX (ciprofloxacin/dexamethasone) FLOXIN (ofloxacin)	CIPRO HC (ciprofloxacin/hydrocortisone)	Non-preferred agents will be approved for patients failing to respond to the preferred agents.
PHOSPHATE BINDERS	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer)		
PLATELET AGGREGATION INHIBITORS	AGGRENOX (dipyridamole/aspirin) clopidogrel PLAVIX (clopidogrel)	dipyridamole ticlopidine	Non-preferred agents will be approved for patients failing to respond to the preferred agents. Dipyridamole will be approved only for patients receiving concomitant aspirin therapy.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
PROTON PUMP INHIBITORS (Oral)[CL] ***Effective 4/1/07*** ***Implement 4/1/07***	NEXIUM Capsules (esomeprazole) PREVACID Capsules (lansoprazole) PREVACID Suspension (lansoprazole) PRILOSEC OTC (omeprazole)	ACIPHEX (rabeprazole) NEXIUM Packets (esomeprazole)[NR] omeprazole PREVACID Solutabs (lansoprazole) PROTONIX (pantoprazole) ZEGERID (omeprazole/ sodium bicarbaonate)	Proton pump inhibitors will be approved for patients meeting one of the following criteria: • Diagnosis of: - Zollinger-Ellison Syndrome - Systemic mastocytosis - Esophageal reflux - Esophagitis - Perforation, stricture or ulceration of esophagus - Concurrent or history of GI bleed, obstruction or perforation - Concurrent or history of complicated PUD - Cystic fibrosis and on pancreatic enzyme treatment - GI organ cancer - NSAID-induced ulcer that requires continued non-selective NSAID therapy - Current H. pylori associated with PUD as part of a 2-4 drug eradication regimen (limited to 3 month duration) - Concurrent therapy with warfarin or corticosteroids Prevacid Solutabs will be authorized for patients meeting one of the following criteria: - age <10 years - has a G-tube - has failed or is not a candidate for Prevacid capsules or oral suspension Non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last 6 months. Quantity limits of one dose per day apply to this class
	H. PYLORI COMBINATIONS		The individual components should be prescribed and dispensed in place of this agent.
		PREVPAC (amoxicillin/ clarithromycin/lansoprazole)	

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS CRITERIA
SEDATIVE HYPNOTICS ***Effective 4/1/07*** ***Implement 4/1/07***	**BENZODIAZEPINES**		Non-preferred agents will only be approved if patient has tried and failed therapy with at least two preferred agents within the last 6 months.
	temazepam triazolam	DORAL (quazepam) estazolam flurazepam RESTORIL 7.5 mg (temazepam)	
	OTHERS		
	chloral hydrate LUNESTA (eszopiclone) zolpidem	AMBIEN CR (zolpidem) ROZEREM (ramelteon) SONATA (zaleplon)	
SKELETAL MUSCLE RELAXANTS	baclofen chlorzoxazone cyclobenzaprine Dantrium (dantrolene) methocarbamol orphenadrine tizanidine	carisoprodol	The non-preferred agent will be approved for patients with documented failure of at least a one week trial each of two preferred agents. For carisoprodol: • use will be limited to no more than 34 days • additional authorization will not be granted for at least six months following the last day of the previous course of therapy • approval will not be granted for patients with a history of meprobamate use in the prevous two years • concurrent use with opioids requires prior authorization

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STIMULANTS AND RELATED AGENTS[CL]	**STIMULANTS**		Stimulants will be approved for patients with one of the following diagnoses in the previous 2 years: • ADD/ADHD (ICD-9=314) – amphetamine salt combination products, dextroamphetamine, methylphenidate products, Focalin, Focalin XR, Desoxyn • Narcolepsy (ICC-9=347) - amphetamine salt combination products, dextroamphetamine, methylphenidate products, Focalin, Focalin XR Stimulants will not be approved for patients with any of the following diagnoses in previous 2 years: • opiate abuse (ICD-9=305.5) • drug dependence: opioids (ICD-9=304.0), cocaine (ICD-9=304.2), amphetamine (ICD-9=304.4), hallucinogen (ICD-9=304.5) • hypertension (ICD-9=401-405) • hyperthyroidism (ICD-9=242) • glaucoma (ICD-9=365) Amphetamine salt combination products, dextroamphetamine and Desoxyn will be approved only for patients ≥3 years of age. Methylphenidate products, Focalin and Focalin XR will be approved only for patients ≥6 years of age. Patients currently on Ritalin LA will be approved to continue on that agent.
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination CONCERTA (methylphenidate) dextroamphetamine FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate	DAYTRANA (methylphenidate)[NR] DESOXYN (methamphetamine) pemoline RITALIN LA (methylphenidate)	
	NON-STIMULANTS		Strattera will be approved for patients meeting at least one of the following criteria: • documented trial and failure of at least one stimulant within two months • diagnosis of tics or anxiety disorder or a history of substance abuse Provigil will be approved for patients ≥16 years of age with any of the following diagnoses in the previous 2 years: • diagnosis of narcoloepsy (ICD-9=347) • obstructive sleep apnea (ICD-9=780.51, 780.53) • shift work sleep disorder (ICD-9=307.45)
		PROVIGIL (modafanil) STRATTERA (atomoxetine)	

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ULCERATIVE COLITIS AGENTS ***Effective 4/1/07*** *Implement 4/1/07*	**ORAL**		
	ASACOL (mesalamine) COLAZAL (balsalazide) sulfasalazine	DIPENTUM (olsalazine) LIANA (mesalamine)[NR] PENTASA (mesalamine)	
	RECTAL		
	CANASA (mesalamine) mesalamine		

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